IN THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT
OF THE STATE OF FLORIDA IN AND FOR HILLSBOROUGH COUNTY
CIVIL ACTION DIVISION

FLOYD J. KENYON, SR. and FLORENCE
KENYON, his wife,
Plaintiffs,

Case No. 00-5401
-vs- Division: "D"
R.J. REYNOLDS TOBACCO COMPANY, a
foreign corporation,

Defendants.
ÄÄ/

TRANSCRIPT OF PROCEEDINGS

BEFORE: THE HONORABLE HERBERT BAUMANN
Circuit Judge
TAKEN AT: Courtroom Number 1
Hillsborough County Courthouse
Tampa, Florida
DATE: 19 November 2001
TIME: Commencing at 9:20 a.m.
REPORTED BY: Sherrill Lynn Jackson, RPR
Notary Public, State of Florida

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(appearances continued on next page)

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ALSO PRESENT:
FLOYD J. KENYON, SR. (Plaintiff)
FLORENCE KENYON (Plaintiff)
DAN DONAHUE (Corporate Rep. of R.J. Reynolds)
DAVID DAVIS (Corporate Rep. of R.J. Reynolds)
RICK STUHAN (Corporate Rep. of R.J. Reynolds)
APRIL GEORGE (Paralegal to Mr. Acosta)
CHARLES WRIGHT (Technical Expert - R.J. Reynolds)

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(9:20 a.m.) P R O C E E D I N G S

THE COURT: Mr. Acosta, Ms. Parker.

MS. PARKER: Morning.

THE COURT: Associated friends.

MR. ACOSTA: Your Honor, may have I introduce Greg Maxwell from Jacksonville, he'll be sitting with me.

THE COURT: Good to see you again. I think he was here on one of the preliminary.

MS. PARKER: Hall.

THE COURT: We ready to go?

MS. PARKER: Your Honor, I have a few matters --

THE COURT: Yes.

MS. PARKER: -- before this particular witness takes the stand.

First of all, I understand from Mr. Acosta yesterday that they do not have biopsy results yet. Those won't be available until tomorrow, but can I do think it would be helpful if we can make clear to the witness that he's not supposed to mention the test or anything after the discovery period, and I don't know if that's been done.

THE COURT: Is that an issue?

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MR. ACOSTA: I have made that known to the witness.

THE COURT: All right. So, it's not an issue.

MR. ACOSTA: Shouldn't be, unless there's a mistake.

THE COURT: All right.

MS. PARKER: Okay.

THE COURT: And?

MS. PARKER: And next thing, this -- we have filed a bench brief on this issue.

This witness has not mentioned anything about causation in any of his medical records, and he should not be allowed to give causation testimony as a result. He can talk about anything that's in his medical records or anything he did during his course of treatment, but causation is not part of it. And we've got three real good cases that we cite in your bench brief right on point that say exactly that. If it's not something disclosed to us, he's not listed as an expert, we got no disclosure on anything relating to causation. If Mr. Acosta now comes in and asks about causation, that would be improper.

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THE COURT: Is that -- one; is that an issue?

MR. ACOSTA: I don't -- it shouldn't be an issue, because he was disclosed. And, secondly, treating doctors aren't experts to begin with, they're doctors.

THE COURT: Is he going to testify about causation or --

MR. ACOSTA: Yes, sir.

THE COURT: Okay. So, causation's an issue?

MR. ACOSTA: Yes, sir, causation's at issue. And I'm prepared to argue why he be permitted to testify as to causation if you want to hear that.

MS. PARKER: Your Honor, may I --

THE COURT: I'll hear the -- here's the thing, I'll hear the testimony as it comes in. I mean, I'll have to just rule on the objections as it's offered. I think Miss Parker's objection is with regard to whether -- as I understand the objection, it's with regard to whether or not defendant was put on notice that this was, in fact, part of this -- part of this expert's or treating

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physician's testimony.
MR. ACOSTA: Yes, sir, they were.
And Interrogatory Number 7, they asked, "These were interrogatories propounded to plaintiff by the defendant." And they asked, "Please identify the name, address and telephone number of each treating physician or each physician, state the subject matter on which the physician is expected to testify." And we disclosed in that answer that the treating physicians identified are expected to testify as to the following: Mr. Kenyon's medical conditions and their cause. Mr. Kenyon's smoking history and the effects, et cetera."
So, we did make that disclosure to them. I have some cases, as well.
THE COURT: Well, let me -- so, Mr. Acosta suggests there was a disclosure.
MS. PARKER: Your Honor, we would disagree with that. That is -- we did not get any type of expert disclosure saying what the causation opinion was, what the basis of it is, anything like that. There's not one word in his medical records along those lines.

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MR. ACOSTA: Well --
THE COURT: Well, we'll -- you wish to make any additional argument? I mean, my inclination is we just start the testimony, I'll hear what he says, and I'll rule as we go along.
I will state that a treating physician, I think, can testify about cause of specific ailments that a patient has, but I don't know what the testimony is. I don't know what he's going to testify to. I'm not sure of the entire package. So, if there's something else you want me to know before he starts testifying, I'll be happy to --
MS. PARKER: Not on this issue now.
THE COURT: Hmm?
MS. PARKER: Not on this issue. I've got two other matters I'll bring to Your Honor.
THE COURT: Okay.
MS. PARKER: I'll just raise my objection as we go along.
THE COURT: As we go along.
MS. PARKER: That will be fine.
The next item Mr. Acosta mentioned to

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us yesterday evening when he called Mr. Fuhrman about the witnesses today that he was going to try to get into evidence a "to whom it may concern" letter that Dr. Williams wrote. That's one of the letters that Your Honor previously --

THE COURT: Correct.

MS. PARKER: -- ruled out of the medical set. And we object to that coming in.

THE COURT: You want to have other argument on it?

MS. PARKER: Pardon?

THE COURT: You wish to have further argument on it?

MS. PARKER: Yes, Your Honor, I --

THE COURT: Okay. We'll just defer that. I won't --

MS. PARKER: As long as we won't use it with the witness.

THE COURT: You're not using it with the witnesses this morning, are you?

MR. ACOSTA: I don't think so, unless I have to, but I don't think I am. There may be a situation where I might have to, but you I don't anticipate it.

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THE COURT: Well, if you have to, I don't know how you would have to, but you can't -- I tell you, you cannot unless you see me first. How is that?

MR. ACOSTA: Be happy to do that.

THE COURT: All right. So, don't use it unless the Court authorizes it.

All right. So, we'll -- and I'll just rule on that later.

Go ahead. After we have argument.

MS. PARKER: And then finally, I anticipate that we're going to have an issue about the proper legal standard on cause that's going to be raised when Mr. Acosta has to ask questions about this witness's opinion, and we've provided Your Honor with a bench brief on that, but Mr. Fuhrman is prepared to argue that.

MR. FUHRMAN: Good morning, Your Honor.

Briefly, there are two potential standards that could be used in this case. One is the traditional "but for" standard, that is "but for defendant's cigarettes Mr. Kenyon could not have develop cancer."

There's also the -- what I call the

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"watered down" standard, if you will, called the "concurring cause" standard, which is where the defendant's cigarettes caused a substantial contributing cause to Mr. Kenyon's cancer.

The only time it is appropriate under the case law to give or to allow testimony under the concurring cause standard is if there are two or more independent causes of an injury that operate at the same time to create a single injury so that you can't tell which one was the only cause.

We don't have that situation in this case, Your Honor. And I would like to very quickly cite for the record the Goldsmith vs. Holeman case, which is a Florida Supreme Court case from 1990, at 571 So.2d 422, which I can bring up a copy to Your Honor which states that: "Concurring causes are two separate and distinct causes that operate contemporaneously to produce a single injury."

Your Honor, one other case I would like to cite is the Stahl, S-T-A-H-L, case, which is a Third DCA case from 1983 at 438 So.2d 14. And the Stahl case is important because it

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gives some examples from Prosser as to what serves as a -- as -- what can be considered a concurring cause, and the two examples that are cited are two motorcycle simultaneously pass the plaintiff's horse, which is frightened and runs away. Either one alone may have caused fright.

And then another example is one defendant sets fire which merges with a fire from some other source and the combined fires burn the plaintiffs' property, that either one may have done it alone.

We don't have a situation like that in this case, Your Honor. There are two separate causes coming from different directions operating at the same time to produce one injury, namely, Mr. Kenyon's cancer, and therefore, a concurring cause standard or opinion testimony, medical opinion testimony based on the substantial contributing cause would be inappropriate in this case, and we would ask that the "but for" standard be used.

Thank you.

THE COURT: Well, a medical treater or a medical expert's going to testify within a

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degree of reasonable-medical probability, and not -- I would dare say most medical experts are not going to testify as to the legal cause -- a legal cause standard. And that coupled with -- I mean, some of this just goes to the weight, because I understand it's a disputed issue as -- you know, plaintiffs are contending one thing, defendants are contending something else, and it is a disputed issue. So, the question -- the issue you raised, I think, is an issue for the -- how I instruct the jury as a matter of law, but not necessarily how the medical provider is going to testify.

MR. FUHRMAN: And, Your Honor, thank you for that. I think maybe this problem won't arise with this particular witness as long as Mr. Acosta does not ask a question such as: "Dr. Williams, would you agree that Mr. Kenyon's cigarette smoking was a substantial contributing cause of his cancer?" I think that's what I'm anticipating a potential problem. That's why I raised it.

THE COURT: Well, he's going to -- he's a medical -- I take it he's a medical doctor,

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and he's going to give his evaluation of this patient in the -- and couch it within a reasonable degree of medical probability, I assume, and that's probably the extent to which a physician can go, because medical -- you know, medical science does not necessarily lend itself to a legal probable cause analysis.

MR. ACOSTA: Your Honor, counsel for the defendant is confused. Two different standards, two different rules.

The standard rule says that -- and this is from the jury instruction, "Negligence is a legal cause of injury if it directly and in natural and in continuous sequence produces or contributes substantially to producing."

THE COURT: Yeah, but that's a jury instruction.

MR. ACOSTA: I understand, but that's the standard. His testimony is going to be whether or not it was a substantial contributing cause of his cancer.

THE COURT: Well, his testimony is -- his testimony is testimony that he's going to provide within a -- within his training and

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medical profession. It's up to the jury to weigh how it applies to the law.

If you ask, though, the question that Mr. Fuhrman just said you were going to ask, that would be leading, and you would get -- you know, an objection would get sustained, at a minimum.

MR. ACOSTA: Well, I wasn't going to lead him, but I'm going to ask him if he has an opinion.

THE COURT: Right, I understand. And then -- I understand that. Most doctors don't talk like lawyers. That's been my experience, but -- we may have an exception.

All right, we've got the one juror out there.

THE BAILIFF: Yes, sir.

THE COURT: All right. Why don't you bring that juror in quickly. I'm going to have -- one of the jurors has pneumonia, is that what she said? Go ahead and bring her in for a second. See how she's doing. Bring her in and find out what her medical condition is.

MS. PARKER: Your Honor, may we approach.

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THE COURT: Uh-huh.

(Thereupon, the following bench conference was had:)

MS. PARKER: I can't help but notice there's a man in the back in a wheelchair, we need to make sure he's not a witness.

MR. ACOSTA: I don't remember --

THE COURT: That's what Kenny -- he is on observer, that's what Kenny just said to me on him. Kenny just thought -- Kenny asked -- Kenny normally ask people as they come in the courtroom if they are witnesses or not.

MS. PARKER: Okay.

THE COURT: This one juror has walking pneumonia according to the juror. I'm just going to see what her condition is and see how she's doing. I understand she's on antibiotics, but I don't know what the -- I hate to go down the -- one of the women that the -- because he referred to her -- so we'll find out.

(Thereupon, the juror entered the courtroom.)

THE COURT: Go ahead and have a seat, ma'am. How you doing today?

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I understand you've got pneumonia.
JUROR #2: It's starting to go into it they think. They don't know for sure.
THE COURT: Have they put you on some sort of treatment or antibiotic?
JUROR #2: Antibiotics.
THE COURT: And you're checking with your physician?
JUROR #2: I have to go to my regular doctor this week, and I ended up in the emergency room. And so they gave me antibiotics, and diuretics for high blood pressure. And then they want me to make an appointment with my doctor and have him look at the test results.
THE COURT: Have you done that yet, made the appointment?
JUROR #2: Not yet.
THE COURT: You feel okay today?
JUROR #2: So far.
THE COURT: Well, you know, if you -- two things, one of which is, there's a bathroom right back there.
JUROR #2: Okay.
THE COURT: You need to use it, just

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jump and go use it and stop. But secondly, if you start -- been, you need a break or something, start feeling bad, let Kenny know or raise your hand and we'll take a break.

The other thing is let -- at one of the breaks when you make -- get something scheduled with your doctor, let us know so we can accommodate you on that too, see how you're doing. Obviously, if you're getting worse, that's -- we'll have to address that. I just want to make sure. You're okay right now?

JUROR #2: I'm okay right, it's the walk from the parking garage that I can't catch my breath and I guess my lungs are not expanding enough or whatever, so -- is there are any parking that's closer?

THE COURT: We can check. We'll check. Kenny -- I'll ask Kenny to check and see what we've got.

JUROR #2: Once I'm here and I'm not moving around, it's not too bad.

THE COURT: All right, thank you for bearing with us. Go ahead and get the rest of the jurors.

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THE BAILIFF: That's where you're sitting, right.
JUROR #2: Yeah.
(Thereupon, the jury entered the courtroom.)
THE COURT: You may be seated.
(Thereupon, the jury was seated.)
Good morning, ladies and gentlemen.
JUROR #2: (Nods head.)
THE COURT: I know I asked you to be here at nine. In the morning, I do have hearings, and sometimes my hearings are -- in your experience probably more -- sometimes all the time, but sometimes my hearings that I have with -- unrelated to this case but other cases, other attorneys run somewhat longer than I would normally like, and, in fact, that's what happened this morning. I had attorneys from as far away from South Dakota had come in for a hearing. So I need to give them some time and I apologize for our late start, but we are now ready to proceed. Mr. Acosta, call your next.
MR. ACOSTA: Thank you, Your Honor. Plaintiff will call Dr. Charles Williams.

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THE COURT: Very good.
THE CLERK: You do swear or affirm that the evidence you shall give in this cause will be the truth, the whole truth, and nothing but the truth?
THE WITNESS: I do.

Thereupon,

DR. CHARLES C. WILLIAMS, JR.,

was called as a witness and, after having been first duly sworn/affirmed to testify the truth, was examined and testified as follows:

THE COURT: Mr. Acosta, you may inquire.

DIRECT EXAMINATION

BY MR. ACOSTA:

Q Thank you, and Your Honor.
Doctor, would you please tell the jury your full name and your address.
A Charles C. Williams, Jr. My address is [DELETED].
Q What is your occupation, sir?
A I'm a doctor.
Q And where do you practice?
A At the University of South Florida, College of Medicine.

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Q And can you tell the jury a little bit about your education and your background in medicine?
A I went to medical school at the University of Pittsburg, graduated in 1973, did post graduate training at the University of South Florida, College of Medicine in internal medicine and also in hematology and oncology.
Q And where did you do your residency?
A Here in Tampa at the University of South Florida, College of Medicine.
Q And can you tell the jury a little bit about any achievements that you might have had when were you a resident?
A Well, I did spend a year as the chief resident over in the training program in internal medicine. Prior to doing a fellowship in oncology and hematology.
Q How many residents were you chief over?
A About 40.
Q And then after you finished your residency, then what did you do?
A I did three years of subspecialty training in hematology and medical oncology.
Q What is oncology?
A Oncology is a broad term that describes

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a field of medicine that deals with cancer and its related problems from treatment to epidemiology, screen and follow-up.

Q And do you make diagnoses of cancer as an oncologist?

A In cancer diagnosis is made by a pathologist. As a medical oncologist, my role is treatment.

Q And what kind of treatment do you provide as an oncologist?

A Try treatment modalities include a combination of chemotherapy, supportive management, pain control and some counseling.

Q And do you read x-rays and CT scans and that kind of thing?

A I do not read x-rays or CT scans as a formal part of my practice. We do look at and review x-rays and CT scans. The reading of x-rays and CT scans is in the purview of radiology.

Q Do you teach medicine?

A Yes.

Q And it how long have you done that?

A For 20 years.

Q And who do you teach?

A Medical students, residents, and we

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have subspecialty fellows.
Q Are you board certified in any specific areas?
A Internal medicine and medical oncology.
Q Do you have a specialty as a medical examiner or certification in that regard?
A I don't understand the question.
Q Diplomate of the National Board of Medical Examiners?
A Yes.
Q 1974?
A Yes. That --
Q What is that?
A That is a -- that means that you passed the licensing examination. That's what that means.
Q Well, what does board certification mean in oncology?
A That means that you have successfully completed an examination in medical oncology, and you're granted certification status.
Q And what position do you hold with the University of South Florida Medical School?
A I'm an associate professor of oncology.
Q And do you have a clinical practice as well?

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A Yes.
Q In what hospitals do you conduct a clinical practice?
A At the H. Lee Moffitt Cancer Center and at Tampa General Hospital.
Q And what kinds of patients do you generally see at H. Lee Moffitt Cancer Center?
A Primarily patients who have thoracic cancers. I do treat some breast cancer, some colon cancer, and I do have some patients who have certain hematologic problems.
Q What is the thoracic area of the body?
A Uh, the chest.
Q So, do you treat lung cancer?
A Yes.
Q And how long have you treated lung cancer?
A 20 years.
Q 20 years?
A Yes.
Q Do you treat patients that have various types of lung cancer?
A Yes.
Q Have you treated Mr. Floyd Kenyon?
A Yes.

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Q Does he have lung cancer?
A Yes.
Q What type of lung cancer does he have?
A Small cell lung cancer.
Q Is that known by any other name?
A Yes.
Q What's that?
A Historically it's called oat cell cancer. Some people would refer to the small cell cancer as neuroendocrine cancers.
Q Now, with respect to small cell cancer, have you treated it before in other patients?
A Yes.
Q What is the frequency -- well, let me ask it this way. Can you give us an estimate as to the percentage of lung cancer patients that you treat that have small cell lung cancer?
A 25 percent of cancer patients who have lung cancer that I treat have small cell lung cancer.
Q Is there any relationship between small cell lung cancer and cigarette smoking?
MS. PARKER: Objection.
THE COURT: I'll overrule it.
THE WITNESS: Do I answer the question?
THE COURT: Yes, you may answer it.

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THE WITNESS: Yes.
BY MR. ACOSTA:
Q What is that relationship?
A Almost all of the patients that I treat with this disease are smokers or ex-smokers.
Q Can you give us some estimate over the years as to how many small cell lung cancer cases you've treated?
A Over how many years?
Q Over 20 years?
A Over 20 years. I treat 15 patients a year with that diagnosis.
Q Then would 300 be an proximate number?
A If that math correct? Yes, I suppose.
Q And of that 300 patients with small cell lung cancer, how many of them were over 50 years old?
A All of them.
Q And all of those that are over 50 years old, do you recall anyone who is a non-smoker?
A One.
Q Does the medical community -- well, let me ask you this: Tell us a little bit about the Moffitt Cancer Center, what -- when was it started?
A The -- the doors opened in 1986. Three

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or four years prior to that, the -- the university, the Moffitt Center was granted legislative approval from the State of Florida to build a cancer center. So, it was completed substantially in '86 and the doors opened and patients began treatment there.

Currently, it is a National Cancer Institute designated comprehensive cancer center, only one in the state of Florida. We do receive state funding and funding through the National Cancer Institute. We provide screen, diagnosis, treatment, research, basic and clinical. We have outreach programs, and we do teach students, graduates. We have a foreign exchange program and visitations.

Q Do you receive patients referred to you from other hospitals?

A Yes.

Q Now, are you the only doctor at Moffitt Cancer Center that treats lung cancer patients?

A No.

Q How many oncologists like you are there?

A There are eight medical oncologists in the thoracic program. We have one designated radiation oncologist in the thoracic program, and because we have a programmatic approach to treatment

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at the Moffitt, meaning that there's a program for breast cancer, there's a program for lung cancer, there's a program for colon cancer, there are medical oncologists in each of those areas. Sometimes there's some overlap.

Q All right.

You -- you mentioned that you treat approximately 15 small cell lung cancer cases a year. What is your knowledge about what the other oncologists in the thoracic area treat? Do they treat something similar to that?

A It would depend on how active they are in the clinic. For example, we have some medical oncologists who are in the laboratory doing the research 80 percent of the time and only 20 percent of the time do they have an active practice.

And under those circumstances, their exposure to patients who have -- the numbers of patients that they would be asked to see and treat would be smaller.

Q Can you -- can you give me an idea then of what the total number of lung cancer patients that are seen at Moffitt each year is?

A 6,000.

Q With lung cancer?

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A Yes.
Q And would 25 percent of those be small cell lung cancer cases?
A Perhaps.
Q And in your -- do you consult with the other doctors about their cases sometimes?
A Yes.
Q And are you knowledgeable about the kinds of patients that they see in addition to your own?
A Yes.
Q And of those 25 percent of -- of 6,000, would that be around 1500 small cell cases a year?
A Yes.
Q Do you know approximately how many of those 1500 small cell lung cancer cases a year occur in non-smokers?
A I don't know, but --
Q Have you heard of any?
A No.
Q Now, when someone comes to Moffitt from another institution, another hospital, is their case worked up by anyone at Moffitt? Could you just briefly describe how it's handled before treatment starts?

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A The -- a person may be referred or sent from another hospital as an in-patient; for example, a hospital to hospital transfer. And under those circumstances, that individual is admitted to the hospital. It is -- that person is seen by several residents and attending staff and the work-up and treatment initiated at that point in the hospital.

Most of the time, patients are referred for an outpatient visit; and under those circumstances, they're assigned to a program, depending on what the problem is.

At that outpatient visit, they may see a primary oncologist as part of their routine evaluation or they may see a nurse practitioner or physician extender who works with a medical oncologist, and they're into the system that way.

If treatment is recommended or deemed appropriate, then they are treated. If it is only for consultation and advice that is rendered, and they go back to the referring institution.

If they are moving and wish to relocate and care established here, we do that; or if they're snowbirds and they're here for the winter and treatment is to be continued, that is done as well.

Q Is there a conference of any kind among

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a team of physicians with respect to a determination of the disease and the course of treatment?

A As part of the -- the teaching and research mission, each program typically has a -- a weekly conference of interested parties to include other specialists and patients are discussed. Treatment is -- is outlined, if that is the issue, or there may be research issues that are discussed. So, this goes on weekly among the various programs.

Q Now, we mentioned a minute ago that most of the small cell cancer patients that you see, all but one, I guess, were smokers.

What is -- do you have an opinion as to whether or not cigarette smoking is a cause of small cell lung cancer?

MS. PARKER: Your Honor, may just have you a continuing objection?

THE COURT: You may.

MS. PARKER: Thank you, Your Honor.

THE COURT: Overruled. You may answer.

THE WITNESS: Yes.

BY MR. ACOSTA:

Q And what is that opinion?

A It's cigarette smoking causes small cell lung cancer.

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Q And is -- is there any serious dispute in medicine about that, to your knowledge?
A No.
Q Now, is small cell lung cancer something that you see in younger patients?
A No.
Q Is there a particular reason for that?
A Well, cancer -- the evolution of cancer takes years, as we know it; 15, 20 years. Cancers are -- they develop in a step-wise fashion. And typically, cancers in younger people develop because of either genetic issues or exposure to physical and chemical agents such as high dose radiation. In the old days in World War II, there were many -- significantly many early cancers in younger people, particularly thyroid cancer and acute leukemia.
However, the solid tumors that we see in adults, the cancers of aging, generally occur in older people, 50 and up.
Q What about in terms of cigarette smokers, is there a particular reason why they're older?
A Well, it has to do with the -- the years of exposure and the availability of cigarettes and tobacco over years, particularly after World War

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II, and the issue of the social acceptance of cigarette smoking during those times.

So that these days, the lung cancers that we see, still, typically, the patients are older, but we do see this occurring in younger people and more so in ladies.

Q Now, did you have an opportunity to treat Mr. Floyd Kenyon?

A Yes.

Q And what did you treat him for?

A Small cell lung cancer.

Q And can you tell us what differences there are -- what distinguishes small cell lung cancer from other lung cancers? Just in general terms?

A In general terms, how it looks under the microscope. The cells are smaller. The chest x-ray pattern classically differs from other lung cancers in that generally there are enlarged lymph nodes in the center of the chest that is typical of small cell lung cancer.

The behavior of small cell lung cancer is such that chemotherapy is the treatment of choice. It was determined many years ago that surgery played no significant role. For other types of lung cancer,

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we do still consider surgery a possible treatment modality, but in small cell, we don't.

Q All right.

And why don't you consider surgery a treatment modality for small cell lung cancer?

A Because typically when it is discovered, it's extensive, meaning it is outside of the chest.

Q And how does it respond to therapy?

A The response to chemotherapy is excellent.

Q Is there a particular reason why small cell lung cancer is typically found outside the chest?

A Because of its growth kinetics.

Q Can you describe -- explain to the jury a little bit about what you mean by growth kinetic?

A What I mean by that is that it is a rapidly proliferating and advancing cancer, as opposed to other lung cancers that may remain localized in the chest.

If there's a local problem in the chest, you can remove it by surgery. However, if there is a rapidly advancing cancer, a local modality of treatment would have no role and would be

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inappropriate.

Q Now, I want to show you one of your records in this case that's already been entered into evidence. I believe that the evidence number is Plaintiffs' Exhibit 508, and then I'll identify the Bates number of this particular document, which is 28557500010. And let me turn on the screen here. I'm sure the fan will go on, so it make take just a second for that to come up.

Dr. Williams, is that your signature there? Can you see that?

A Yes, that is my signature.

Q Now, I want to ask you some questions about some of this. Let me see if I can make this a little bit bigger.

Where I've underlined it there, it says "computerized" -- And this is a record of Mr. Kenyon; is that your understanding?

A Yes.

Q We can go up and I can show that to you. But this is Mr. Kenyon's record, and let's identify the date, which is May 1st, 2000. Is that about the first time you saw Mr. Kenyon?

A Yes.

Q And who is Dr. Grill?

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A We've never met. He is the doctor from Sarasota who referred Mr. Kenyon to our program.
Q So, Mr. Kenyon came to you from Dr. Grill's care in Sarasota; is that what happened?
A Yes.
Q And then what -- what did you do upon seeing doctor -- I mean, seeing Mr. Kenyon?
A I --
Q Is this -- does this -- this record here reflect your visit with Mr. Kenyon?
A Yes.
It is a letter to Dr. Grill which I can't read -- read all of the details, but I believe it reflects the fact that I saw him, what we thought and what we recommend.
Q Okay.
I may need to move that screen up. Let me see if I -- I've got a copy of this. Maybe this would help you read along.
May I approach, Your Honor?
THE COURT: You may.
MR. ACOSTA: Maybe this will help (handing item to the witness).
THE WITNESS: Okay.
BY MR. ACOSTA:

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Q Now, when you take on a new patient such as Mr. Kenyon, what do you specifically do to work up his case?

A We take a history and physical. And if there are x-rays or scans for review, we review them. If there are issues identified in the history or physical which require further evaluation, we recommend appropriate further testing and study. And then we outline a plan of treatment, which may be implemented in the patient's own home community or locally.

Q Does this second paragraph of your letter summarize briefly your history and -- and some of the physical findings that you determined?

A Yes.

Q And it indicates that computerized tomography scan of the thorax on 4/10/2000 revealed a right hilar mass.

What is a right hilar mass?

A A right hilar mass is -- the hilum is the center of the chest. So, you have a right lung and left lung, and where the major airways branch, that's called the hilum. And so there was a mass centrally in the center of the chest on the right side.

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Q What does the term "mass" signify, if anything?
A Mass can be a cancer. It can be an abscess. It is a general non-specific term for collection of tissue.
Q And what is computerized tomography?
A That's a -- that's a scan. It's a -- it's called a CAT scan. And it's a -- it's really a cross-section of the chest, as if you'd slice a banana or carrot. The computerized -- a tomogram are slices. So, sections through the chest are taken and it's done on a computer and you get an image. And it's better than a chest x-ray.
Q Better than a chest x-ray? Is the image something that appears on a big film?
A Yes.
Q And then it's read by someone?
A Yes.
Q And it says there was extensive mediastinal adenopathy? What is mediastinal adenopathy?
A The mediastinum is a space in the center of the chest where the hearts sits and where the esophagus goes through there. There are lymph glands in the mediastinum and -- and when these lymph

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glands are enlarged, the term is adenopathy. And the fact they're in the mediastinum, that's what that means, mediastinal adenopathy.

Q In Mr. Kenyon's case, do you have an opinion as to what caused his lymph nodes or lymph glands to enlarge?

A Well, if there's a mass in the chest and cancers of the lung spread through the lymphatic to lymph nodes. They also can spread through the bloodstream, but seeing a right hilar mass and mediastinal adenopathy is a classic finding to suggest that this is a lung cancer by CAT scan.

Q Are these lymph nodes outside the lung?

A Yes, they are.

Q And the lung cancer itself is inside the lung?

A It may be inside the lung or in the airway.

Q How -- how does it cause the lymph glands outside the lungs to enlarge?

A Because the cancer spreads along the channels that go through these lymph nodes and cancer cells get in the lymph glands and start to grow and make them bigger.

Q Then it says, he had obstruction of the

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right upper lobe bronchus; what does that mean?
A The cancer had grown such that the right upper lobe bronchus was compressed like a fish mouth, if you would.
Q And how does that affect the functioning of -- well, first of all, how many lobes are in the -- the lung?
A Well, as a general rule, there are three on the right, the right lung is the largest; there are three lobes, there's upper, middle and lower. The left lung has two, an upper and a lower.
Q So, this would be the right upper lobe?
A Yes.
Q One of five.
Did the closing off of the bronchus affect the function overall of his breathing capacity?
A Yes.
Q And then it says next that there was atelectasis of the right middle lobe bronchus; what does that mean?
A That means that the -- the right middle lobe bronchus or the airway going to the right middle lobe was compromised as well. And the term "atelectasis" means that the lung has -- could not

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expand. It was collapsed.
Q And next up there, it says -- let me see if I can find my -- it says up here, "There was encasement of the superior vena cava."
What -- what -- first of all, what is the vena cava?
A That's a -- the vena cava is -- is a vein. It's a thin-walled vein that -- that accepts blood from the head and the feet and the lower body. And this venous blood goes into this vein that sits on the right side of the chest into the heart. So, that's what the vena cava is.
Q And what -- what does it -- what did you mean when you said there was encasement of the superior vena cava?
A The cancer was around it, squeezing it.
Q And what effect does that have?
A What that does is that venous blood can't come from the head and get to the heart and the face and the eyes and the lips and those swell. And people get more short of breath and have more trouble breathing and arms could swell or legs could swell as well.
Q Now, it says "And there was concern of the full syndrome." What did you mean by that?

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A I just described the full syndrome. Full syndrome of superior vena cava would be swelling of face, eyes, lips, nose, neck, both arms, and associated with shortness of breathe, maybe low blood pressure. Distressful circumstances.

Q Now, up here earlier in this report it indicates, I believe that Mr. Kenyon also had some sleep apnea?

A Yes.

Q Is that related at all to this?

A This -- this cancer problem may have worsened the sleep apnea problem.

Q Next, it indicates bronchoscopy revealed -- bronchoscopy revealed an obstructing mass and biopsy was positive for small cell lung cancer. What is a bronchoscopy?

A Bronchoscopy is an examination of the airways. A flexible tube is put into the nose and the back of the throat and the voice box are numbed and with this little instrument, if you examine the voice box and inside of the airways.

Q Now, on the next page in the middle of the page, it says "socially he's a retired high school principal and store owner. He smoked cigarettes for 40 years, two and a half to three

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packs per day and stopped 17 years ago."
Has -- is there any significance to that in Mr. Kenyon's case?
A Yes. He was a smoker with lung cancer -- diagnosed with lung cancer, and this is part of the social history that's on a questionnaire. Because it represents a -- a risk factor for medical problems of which cancer is one.
Q Is that why you want to know what his smoking history was?
A Yes.
Q Are you interested in what causes his lung cancer?
A We're interested in background information and epidemiology in regards to planning treatment, because people who have lung cancer have -- may have other minimum problems. And relationship to tobacco can make one more sensitive or aware of these other problems. So it's included in -- as a standard question and an issue with regards to history-taking.
Q In terms of Mr. Kenyon back at the time that you first saw him, did you form an opinion as to whether or not cigarette smoking was a cause of his lung cancer?

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A I had an opinion.
Q What was that opinion?
A That the two are related. The problem that he had and cigarette smoking was related.
Q Now, in terms of the relationship, can you explain what that relationship was in his particular case?
A In his particular case, very likely that cigarette smoking caused lung cancer.
Q And is that so despite the fact that it says at the time you thought that he had smoked 17 -- stopped smoking 17 years earlier?
A Yes.
Q Now, next on the report -- you say that you recommend that the patient undergo repeat studies. And you say, "I explained that he's had emergent radiation and there's still some effect." What does that mean, that he's had emergent radiation and there's still some effect?
A He was -- he was treated as an emergent before we saw him at another institution because it of difficulty breathing and, in fact, that he was passing out and having trouble breathing. So, he was given some radiation therapy before we saw him. And what I meant by that is that the radiation had had

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some benefit.
Q Then if it says "the treatment of choice for this problem is chemotherapy, and we will expedite this as soon as possible." What did you mean by that?
A That we would begin chemotherapy as soon as feasible.
Q Why do you do that?
A Because allowing the disease to regrow or get worse without active treatment is not a good thing.
Q Then near the bottom it says "he's been scheduled to continue treatment this week, and it may be necessary to deliver radiation therapy at a later date to -- to the central disease. His stage is unknown, however. Pleural effusion would suggest that it's extensive in the thorax."
First of all, what did you mean by "pleural effusion"?
A On the CAT scan, on the x-ray, there was a -- an effusion is fluid. The word "effusion" means fluid, so that there was fluid in the chest pushing the right lung away.
Q Where does that fluid come from?
A It comes from blockage of the lymphatic

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where drainage channels in the lung. It can occur if there's cancer along the lining of the lung, and the lining weeps and fluid is there.

Other circumstances like a pneumonia, there can be irritation of the lining of the lung and pneumonia can cause fluid along the lining of the lung.

In the setting of lung cancer, generally it's either cancer involving the pleural space or the lining around the lung or it's due to an obstruction.

Q And what happened with that initial pleural effusion?

A I don't remember --

Q In Mr. Kenyon?

A I -- as I mentioned we did not sample it, and in small cell lung cancer, when we see a pleural effusion, the assumption is it's related to the cancer, which would make the patient extensive, and according to this note, we went ahead and recommended treatment.

Q And do you remember what the result of the treatment was with Mr. Kenyon?

A He -- we were able to make the cancer shrink in the chest with chemotherapy and radiation.

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Q And is that a typical response to the chemotherapy that you provided?
A Yes.
Q How -- can you tell the jury what chemotherapy is for a patient or what it was for Mr. Kenyon?
A I don't understand the question.
Q Well -- I'd like you to sort of describe what the course of chemotherapy was for Mr. Kenyon.
A Okay. In cancer treatment, chemotherapy refers to drugs that are cell poisons. Generally they're given by intravenous injection on a schedule. In general terms they're associated with certain not so pleasant effects which we can modify, such as nausea, vomiting, hair loss, fatigue, low blood counts.

In the setting of this circumstance with Mr. Kenyon, his treatment was with two drugs delivered three days in a row for about an hour and a half each time. And that process was repeated every three weeks. And I believe he had four treatments. So three days in a row, 21 to 28 days with three treatments. And he also had chest radiation.
Q Now, I want to show you another record

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here. It's dated May 25th, 2000, about a month after the last one. And for the record the case number is 2855750000349. This is another record signed -- signed by you, Charles Williams up there.

What I want to ask you is -- the first paragraph you indicate that he has known endobronchial disease. What did you mean by that?

A I meant that on the bronchoscopy test they saw something in the airway. And that's endobronchial. So that there was something inside the airway.

Q Now, on the next page -- Your Honor, might I move the screen a little closer and see if we can blow that up a little bit? I don't think I have another copy of that?

THE COURT: Can everybody see or does anybody -- raise your hand if you a problem seeing the screen.

(No response.)

MR. ACOSTA: Okay.

THE COURT: Seems to be fine, other than -- do you have the document there, Mr. Acosta?

MR. ACOSTA: Yes, I have a copy of it right here, Judge.

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THE COURT: Go ahead and bring it up.
BY MR. ACOSTA:
Q On the second page there, it says he has a history of sleep apnea an chronic obstructive lung disease. What -- what is meant by chronic obstructive lung disease?
A That's -- another term for that is emphysema.
Q Emphysema?
A Emphysema is -- emphysema is part of the spectrum of chronic obstructive lung disease as a bronchitis. Emphysema and chronic obstructive lung disease may have many causes, common etiologies of tobacco inhalant use. It's a destructive process.
Q Again, it says he's on no new medication but on oxygen almost 24 hours daily. What was the reason for that?
A The reason for 24-hour oxygen was the fact that he came with a history of passing out and having sleep apnea, stopping breathing. And he was also -- in the history there was a history of heart failure associated with his lung problem. So, oxygen is a way to address those issues if you provide supplemental oxygen.
Theoretically the heart works better

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and if you stop breathing when you go to sleep, you have sufficient oxygenation so that one doesn't get a heart attack or a variety of other problems. So, continuous oxygen was recommended.

MS. PARKER: Your Honor, may we approach.

THE COURT: You may. Excuse us, ladies and gentlemen.

(Thereupon, the following bench conference was had:)

MS. PARKER: Your Honor, this issue about the heart came up at a pretrial conference. Your Honor asked Mr. Acosta very clearly if there was anything -- any issues in the case other than COPD, lung cancer. Mr. Acosta said, no, there were not, there's nothing in the pretrial about that.

MR. ACOSTA: We're only seeking damages for his emphysema and his -- and his -- but in terms of it aggravating his whole lifestyle, he can't walk. That -- I'm not going to explore this at any great length.

THE COURT: All right. So he's moving on. He's moving on.

MS. PARKER: I'd like to go to a little

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instruction to the jury. There's nothing in the case with respect to that issue.

THE COURT: Well, I'm happy to do that. I'm not going to do that right now until the testimony is complete, but if you have -- you want to agree to, I'll do that. My understanding is that that is the case; correct?

MR. ACOSTA: And I have alleged and the pre-trial order indicated that pre-existing condition -- aggravation of pre-existing conditions would be included in our claim.

THE COURT: That's fine. You just move on. We'll get to the end of this witness.

(Thereupon, the bench conference was concluded.)

THE COURT: All right. Go ahead, Mr. Acosta.

BY MR. ACOSTA:

Q Thank you, Your Honor. Let me go to the next record that I wanted to show you, Dr. William.

THE COURT: Do you have a copy of that?

MR. ACOSTA: I think I do.

Q Now, the question -- this -- this

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paragraph that's near the beginning, this record is dated 12/19/2000. So that's last December. And I mean, let me get the Bates numbers for the record. Which is 285-57-500207. And it says: "He's had four courses of therapy. He's completed chest radiation to a total dose of 57 GY. And he has also completed brain radiation for prophylaxis to a total dose of 36 GY as of 11/15.

What did you mean by "he's completed brain radiation for prophylaxis?

A The -- his head was exposed to radiation. And some patients who have small cell lung cancer who have a complete response in the chest, brain radiation minimizes the likelihood of having the cancer reappear in the head. It doesn't take away, it minimizes it.

So, as a prophylactic measure radiating the head or exposing the brain to radiation may confer survival benefits in people who have had a good response to chemotherapy. So prophylaxis is preventative, if you will.

Q Okay. Then it says "there is currently if -- he is currently symptomatic with dysmnesia on minimal exertion and he has easy fatigue.

What is dysmnesia?

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A He's short of breath when he does something.
Q Let me go down here to the bottom. And down at the bottom, you conducted a physical examination of him on or about that day?
A Yes.
Q And you checked his chest?
A Yes.
Q And one of the findings here on this report says "he has decreased breath sounds bilaterally.
Is there any significance to that?
A Yes. In people who have chronic obstructive lung disease, they're -- when you listen with a stethoscope, they're -- the lung sounds are muffled, if you will. In people who have fluid pushing the lung away, you may not hear lung sounds on one side, and in a numeral thorax or a traumatic injury to the chest where there's a collapsed lung, you listen. You don't hear anything. So diminished breath sounds is consistent with the fact that a diagnosis of chronic obstructive lung disease and may have fluid in the bronchus at the base of it.
Q Okay. Let me go to the next one. Which is dated August 6th, 2001. If I may approach?

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THE COURT: You may.
BY MR. ACOSTA:
Q (Hands item to the witness.) And is this your record, Doctor, from back in August?
A Yes.
Q Of this year, just a few months ago?
A Yes.
Q And it's Bates number 285-57-5240. And again, it refers to chronic obstructive lung disease. And I -- I guess I have a question for you. Do you know whether this chronic obstructive lung disease had changed from the first time that you saw him?
A No. I didn't feel that it had changed. It got worse.
Q Then it says "he is on no new medication, but on oxygen almost 24 hours daily.
Why is he, why was he on oxygen 24 hours a day?
A Well, he had underlying lung damage before treatment was started. He had had chest radiation, and radiation to the chest to control a cancer destroys the lung that's around that. So, he lost some lung function as a part of the treatment, which was expected. And so, the oxygen requirement would have needed to have continued because he had --

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Q All right. Then if you turn to the last page, just above the note that says that you dictated this. It says "I have also asked that the patient undergo ultrasound guided therapeutic thoracentesis of the fluid for cytology to follow up with his physicians and as appointed.
First of all what is thoracentesis?
A That's a needle or tube in the chest to remove fluid.
Q Why is that done?
A Fluid in the chest -- the pleural space compromises the ability of the lung to expand. If someone is short of breath and it is due to the fluid that is there, one can relieve the breathing problem by taking it out.
Additionally in patients who have been treated for cancer, fluid in the chest might suggest that there is more cancer that is a problem. So removal of the fluid is the real way to address that.
Q So, you're familiar with the term "full remission"?
A Yes.
Q As of August of this year do you have an opinion as to whether Mr. Kenyon was in full remission?

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A No. The term "remission" is typically applied to the cancers of bone marrow leukemia to lymphomas. And what that really means is when you do bone marrow tests and you don't see any leukemia in the bones.

In lung cancer or colon cancer or breast cancer you generally don't say remission. I use the term "response or control." So, I don't know in August whether or not Mr. Kenyon was in control or remission. There was fluid in the chest. And I had recommended further -- of that fluid sample.

Q If it turns out that the fluid sample was negative, would that have any affect on your opinion?

A No, because the fluid can be positive and the issue is that of a sampling error.

Q Pardon me?

A A sampling error.

Q Oh, I see.

A Sometimes more than one sample was required to make that determination.

Q Now as of August of this year were you planning to follow Mr. Kenyon?

A Yes.

Q And as of August of this year, what was

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his prognosis?
A Guarded. Guarded.
Q What does that mean?
A That means that Mr. Kenyon -- Mr. Kenyon came to the table with a background of medical problems. One of which was a cancer that we treated aggressively. The description in the notes that he's very disabled, doesn't do much and he's on oxygen. Under those circumstances, when you factor in coal morbid or other illnesses and cancer treatment, one must exercise caution at the sign of prognosis.
Q You said that he doesn't function -- any question is, is he able to function?
A No.
MR. ACOSTA: Thank you, Doctor, that's all the questions I have.
THE COURT: Thank you, Mr. Acosta. Ms. Parker, before we start, we'll go ahead and take a 15-minute break, then we'll return for cross-examination.
(Thereupon, the jury exited the courtroom.)
THE COURT: Okay, Dr. Williams, you're in the middle of your testimony. So you can't

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talk to anybody about your testimony. Okay.
THE WITNESS: Okay.
THE COURT: You're free to get down and walk around for 15 minutes. We'll be in recess for 15 minutes.
(Thereupon, a recess was had from 10:35 a.m. until 10:50 a.m.)
THE COURT: You ready, Ms. Parker?
MS. PARKER: I'm ready, but the witness has a scheduling problem, I understand.
THE WITNESS: I'm seeing patients at 11:10 at another facility.
THE COURT: You need to call out there and let them know you're going to be running late?
THE WITNESS: Well, I did call out there and let them know I was running late. She tells me this will go for another hour, which is a problem for me.
THE COURT: Yeah.
Well, it's probably -- which facility do you have to go to?
THE WITNESS: I have to go to the Moffitt.
THE COURT: Back to the Moffitt Center?

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THE WITNESS: Back to the Moffitt.
THE COURT: You want to call out there and see if somebody can cover for you until you get back? It's -- the -- we need to finish it. So, I mean, it's -- it's easier just to get it done now than to have you return at some other time, because it's -- otherwise, you're going to -- you're going to be in the same boat.
THE WITNESS: All right. Okay, fine.
THE COURT: You want to call out there?
THE WITNESS: Well -- I did already. Okay. Fine, we'll just go ahead. So -- we'll just go ahead.
(Thereupon, the jury entered the courtroom.)
THE COURT: You may be seated.
(Thereupon, the jury was seated.)
THE COURT: Ms. Parker, you may proceed.
MS. PARKER: May it please the Court. Good morning, ladies and gentlemen.

CROSS-EXAMINATION

BY MS. PARKER:

Q Good morning, Dr. Williams.

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A Morning.
Q I'm Stephanie Parker and I represent R.J. Reynolds Tobacco Company. And I have some questions that I'd like to ask you this morning.
First of all, cancer is not just one disease; instead, it's a number of different diseases, correct?
A Yes.
Q For example, it would be carcinomas, sarcomas, lymphomas, as well as other ones, malignancies, correct?
A Correct.
Q And the identification of different types of cancer depends on what organ it arose in, as well as the type of cell; correct?
A That's correct.
Q And that's true of lung cancer as well; correct?
A Yes.
Q The word "lung cancer" encompasses many different types of diseases?
A That is correct.
Q Correct?
And cancer can be classified as either a primary or metastatic disease; correct?

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A Yes.
Q And primary means that it started in that organ; correct?
A Yes.
Q And metastatic means it started somewhere else and then spread to that organ; correct?
A Yes.
Q So, for example, if someone had -- just for example, if someone had breast cancer that spread to their lung, they wouldn't have lung cancer, instead, they have breast cancer that spread to the lung; correct?
A Yes.
Q Let's talk about small cell lung cancers. All right?
Now, small cell lung cancers occur in non-smokers; correct?
A Yes.
Q And are you aware of a study here in Tampa at USF that showed that the proportion of small cell carcinoma did not appear to differ greatly with smoking status? Are you aware of that study by Dr. Heather Stockwell?
A No.

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Q You're not aware of that?
A No.
Q Do you know Dr. Stockwell?
A Yes.
Q And you understand that she was a former faculty member at the University of South Florida?
A Yes.
Q Let's pull back up Number 1.
MR. ACOSTA: I have an objection, Your Honor.
THE COURT: Is this -- this is one of the documents that is in evidence? Is that correct?
MS. PARKER: No, Your Honor, this is one I'm using for cross-examination.
THE COURT: All right. Just approach for a second then.
(Thereupon, the following bench conference was had:)
THE COURT: What's the objection?
MR. ACOSTA: The objection is he's not familiar with the study. I don't think she can show him studies he's not familiar with.
THE COURT: Well -- I mean, his

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familiarity is not, you know -- he -- the question -- the question -- my only issue is it's not in evidence at this point, correct?

MR. ACOSTA: She would have show it's an authoritative study.

MS. PARKER: I believe I can do that.

THE COURT: Do you want to just hand him the study first? If he recognizes it, I'll let you put it up -- once he -- once you -- if you show it to him as a paper document, then after you lay a foundation --

(Thereupon, the bench conference was concluded.)

MS. PARKER: Your Honor, may I approach the witness?

THE COURT: You may.

MS. PARKER: (Hands item to the witness.)

BY MS. PARKER:

Q Dr. Williams, I've handed you a copy of the study that I was just asking you about. It's reported in the International Journal of Epidemiology; do you see that?

A Yes.

Q Are you familiar with that journal?

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A Yes.
Q That's an authoritative journal in the area of epidemiology; correct?
A Yes.
Q And I believe you told us earlier that you know Dr. Stockwell was as a former faculty member at USF?
A Yes.
MS. PARKER: Your Honor, may I display it?
THE COURT: You may.
BY MS. PARKER:
Q Dr. Williams, this study states that it included over 35,000 cases of lung cancer diagnosed between 1981 and 1985 in Florida; correct?
A Yes.
Q Now, let me ask you, if you will, to look at the next screen here from the study. That study concluded that the proportion of small cell carcinoma did not appear to differ greatly with age or smoking status. Do you see that?
A Yes.
Q You don't have any reason to disagree with the study, do you?
A No.

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Q All right. Thank you.
Dr. Williams, small cell lung -- I'm sorry, small cell cancer can occur in other parts of the body besides just the lung; correct?
A Yes.
Q In fact, small cell cancer can arise in virtually any organ in the body; correct?
A Probably.
Q All right.
And that includes locations that have never been associated with cigarette smoking? For example, prostate, the skin; correct?
A Yes.
Q And by the way, your opinion that Mr. Kenyon has small cell lung cancer is based entirely on what the pathologist said in the case; correct?
A Yes.
Q And the pathologist is the one who gets the tissue sample, puts it under the microscope, looks under the microscope and determines what type of cancer it is; correct?
A That's correct.
Q And that's not a determination that you made yourself; correct?

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A That's correct.
Q Now, Dr. Williams, as a doctor, you routinely tell your patients who smoke that they should stop smoking; is that correct?
A Yes.
Q And have you done that since you first started practicing medicine many years ago?
A Yes.
Q And, in fact, at USF where you teach, your -- the students there are also taught to tell their patients who smoke that they should stop smoking; correct?
A That's correct.
Q And you tell your patients that they should stop smoking because if they stop, that reduces their risk of getting diseases associated with smoking; correct?
A That's correct.
Q And that concept is known as risk reduction in the medical field; correct?
A Yes.
Q And that's why you, as a doctor, tell your patients who smoke or tell people who smoke, that they should quit; correct?
A Correct.

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Q Let me pull up record Number 3. Let me show you one of your medical records here. And Mr. Acosta showed this to you when he was asking you questions.

But your medical record there to Dr. Grill said that Mr. Kenyon stopped 17 years ago; correct?

A Yes.

Q Did you get that information from Mr. Kenyon?

A From his questionnaire.

Q From information he provided?

A Yes.

Q So, this letter is dated May 1st, and 17 years prior would have been around 1982, 1983; correct?

A Correct.

Q Dr. Williams, do you agree that medical authorities and medical studies show that after a person quits smoking for 10 to 15 years, that their risk of developing lung cancer from smoking has dropped back down or almost back down to the level of someone who has never smoked?

A I would agree with that.

Q You would agree with that?

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A (Nods head.) Yes.
Q Now, I'm going to go back and ask you about 1950. Mr. Kenyon did not have lung cancer in his body in 1950; correct?
A That's correct.
Q And then in 1964, which is when the Surgeon General's report came out on smoking and health, Mr. Kenyon didn't have lung cancer present in his body in 1964 either; correct?
A I don't know.
Q Do you have any reason to believe that his lung cancer was --
A I have no reason to believe that he did.
Q You would agree he did not?
A Correct.
Q All right.
And then same thing about 1966 when the first labeling went on the cigarette packages; did Mr. Kenyon have lung cancer present in his body at that point in time?
A I don't know.
Q Do you have any reason to believe that he did?
A No.

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Q Back in 1982, when Mr. Kenyon told you on the questionnaire that he had quit smoking, he didn't have lung cancer present in his body at that point in time either; correct?
A Correct.
Q And he also didn't have lung cancer present in his body in 1992; correct?
A Correct (nodding head).
Q Now, Dr. Williams, would you agree that lung cancer is called a multifactorial disease?
A I agree.
Q All right.
And what that means is that lung cancer has any number of potential causes, factors; correct?
A Yes.
Q Let me ask you about some of those risk factors now. You and I agree that smoking is a risk factor for lung cancer?
A Correct.
Q But there are other risk factors for lung cancer as well; correct?
A Correct.
Q The studies that recognize that environmental exposures create risk factors for the development of lung cancer; correct?

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A Correct.
Q And one of those environmental exposures that's been recognized as a risk factor for lung cancer is air pollution; correct?
A Correct.
Q Have you done any investigation or any study of Mr. Kenyon's living experiences and, in particular, were you aware that Mr. Kenyon lived right outside of New York City for almost 60 years? Were you aware of that?
A No.
Q Have you done any type of study to determine whether or not Mr. Kenyon did or did not have any air pollution risk factor here?
A No.
Q And so, you haven't evaluated, for example, the pollution levels in New York City or anything like that?
A No.
Q And exposure to asbestos is also a risk factor for lung cancer; correct?
A Yes.
Q Including for small cell lung cancer?
A Possibly.
Q Are you aware that Mr. Kenyon has

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worked in schools -- I know you knew he was a high school teacher and principal. Are you aware that he worked in schools for about 30 years that had significant levels of asbestos that were found? Did you know that?

A No.

Q Okay.

Have you done any type of evaluation with respect to Mr. Kenyon to determine whether or not his asbestos exposure was a risk factor for lung cancer?

A No.

Q And another factor that's been linked to lung cancer in recent years has been diet; correct? Let me be more specific; high-fat diet.

A That has been suggested, yes.

Q It's been suggested in peer reviewed medical journals as a possible risk factor; correct?

A Yes.

Q And also, you have not evaluated Mr. Kenyon to determine whether or not he had such a diet that may be a risk factor for his lung cancer; correct?

A Correct.

Q And alcohol is also a -- has been

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recognized as a carcinogen; correct?
A Yes.
Q And are you aware that the Surgeon General has recognized that alcohol is a risk factor for lung cancer? Did you know that one way or the other?
A No, I did not.
Q But you do recognize that there have been studies and peer review medical journals that have recognized alcohol as a risk factor for lung cancer?
A Yes.
Q And have you done any type of study to determine whether or not Mr. Kenyon had any history of alcohol abuse? You know, whether he drank wine or beer or anything and to determine whether that history is a risk factor for his lung cancer?
A No.
Q Have you done that type of evaluation?
A No.
Q Now, you also understand that genetics can play a role in the development of lung cancer; correct?
A Yes.
Q Okay.

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And to your knowledge, has any -- has any genetic testing been done on Mr. Kenyon? A p53 testing, a KRAFT testing, anything like that?

A No.

Q To your knowledge, it has not been done?

A It's not been done.

Q All right.

And finally, there's some cancers that have no known cause; correct? We just don't know what causes it?

A That's correct.

Q Dr. Williams, there's no known test, medical or scientific test, that can be done on a particular individual to determine whether or not that particular individual's lung cancer was or was not caused by smoking; correct?

A Correct.

Q There's no x-ray or CT scan or blood test, nothing like that, that can be done to answer the question of was that individual's lung cancer caused by smoking or not; correct?

A That's correct.

Q Now, would you agree that statistics alone cannot prove causation in a particular

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individual?
A That's correct.
Q And by definition, statistical association and causation are two different things; correct?
A That's correct.
Q That's because statistical studies are about the population as a whole; correct?
A Yes.
Q And human beings are individual and unique, and so those statistical studies may not apply to particular individuals; correct?
A Correct.
Q Dr. Williams, would you agree that the great majority of smokers never develop lung cancer?
A I agree.
Q In fact, only about ten percent of smokers ever get lung cancer; correct?
A Correct.
Q And so, in other words, that means 90 percent of people who smoke never get it; correct?
A Correct.
Q And we've already talked a few minutes ago that non-smokers get lung cancer also, and no one knows why some people get lung cancer and others

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don't, correct?
A Correct.
Q No one knows why some smokers get it and other smokers do not, correct?
A Correct.
Q And no one knows how to predict among non-smokers which ones will get lung cancer and which ones won't get it, correct?
A That's correct.
Q Now, how -- the way that a substance, regardless of what it is, but the way in which a substance causes lung cancer is called a mechanism, correct?
A Yes.
Q And nobody knows the mechanism by which lung cancer is caused; correct?
A Correct.
Q That just has not been discovered yet; correct?
A Correct.
Q Dr. Williams, I'm going to ask you just a few questions about your background. I know you told us a little bit about Moffitt and you mentioned, I believe, it was opened in 1986; is that correct?
A That's correct.

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Q Okay. I looked on y'all's Web site, and it says on our Web site, I'm going to ask you if you're aware of this, that the original hospital at Moffitt was built with money from the State tax on cigarettes. Did you know that?
A Yes.
Q Now, at Moffitt, you work with other doctors, you have a team; correct?
A Correct.
Q And you, as an oncologist direct the team, is that the way it works?
A No. We participate.
Q So, you all work together?
A Yes.
Q All right. Some of those other team members would be a radiation oncologist; correct?
A Correct, yes.
Q A pathologist; correct?
A Yes.
Q Perhaps a surgeon in some cases?
A Yes.
Q A nurse and a social worker?
A (Nods head.)
Q And, in fact, here with respect to Mr. Kenyon, he was treated by a number of different

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doctors; correct?
A That's correct.
Q And that's reflected in his medical records?
A Yes.
Q All right. Let me ask you about your expertise in some of these areas now. You told me you were not a pathologist; correct?
A That's correct.
Q Again, just to remind everybody, the pathologist is the doctor who gets the tissue sample, puts it on a slide, puts it under the microscope, looks under the microscope at that tissue; correct?
A Yes.
Q And the pathologist is one who diagnoses whether or not a person has cancer; correct?
A That's correct.
Q So, when that person comes to you, that's not a diagnosis you made? That's already been made by the pathologist; correct?
A That's correct.
Q And then you also said you're not a radiologist; correct?
A That's correct.

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Q And you're not a pulmonologist either; correct?
A Correct.
Q And you don't hold yourself out as an expert in carcinogenesis; correct?
A That's correct.
Q And by carcinogenesis, I mean what causes cancer; correct?
A Correct.
Q Have you ever published anything on cancer causation?
A No.
Q And I understand, again from y'all's Web site that Moffitt has -- it's called a Cancer Research Center; correct?
A Correct.
Q Do you work there at all?
A Yes.
Q Do you will conduct any research currently on lung cancer?
A Clinical research.
Q Do you -- do you do any research on causation of lung cancer as opposed to treatment?
A No.
Q So your research is focused on the

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treatment?
A Yes.
Q All right. I understand. Thank you.
And you're not a molecular biologist; correct?
A No.
Q We put up the medical record that had a little bit of information that you had obtained from Mr. Kenyon about his smoking history. And that was information that he had told you he had told your office he had quit in 1982.
Do you know anything else about Mr. Kenyon's smoking history like, for example -- do you know happen brands he smoked?
A No.
Q Do you know whether he smoked a full flavored cigarette or a light cigarette?
A No.
Q Do you know whether it was a filtered cigarette or non-filtered?
A No.
Q Do you know anything about tar and nicotine yields of the cigarettes he smoked?
A No.
Q On another topic, you know Dr. Alan Goldman?

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A Yes.
Q And Dr. Goldman is a doctor here in Tampa that you have worked with; is that correct?
A Yes.
Q And in fact I understand you co-authored a publication with him back in 1981; correct?
A Yes.
Q So, you've known him for a while?
A Yes.
Q All right. And you understand that he's listed as an expert witness in this case by Mr. Acosta?
A Yes.
Q Did you know that?
A Yes.
Q Do you know what Mr. -- I'm sorry, what Dr. Goldman's opinions are in this case?
A No.
Q Now, let me ask you some more questions about Mr. Kenyon's lung cancer. Small cell lung cancer, when it spreads, it typically -- sorry typically goes to bone, brain, liver, or adrenal glands; correct. Would those be the four most common sites where it would spread?

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A And to the other lung.
Q Outside the chest?
A (Nods head.) Yes.
Q I apologize. Let me ask my question again. If it spread outside the chest, would you agree that the four areas that's most likely to spread to are bone, brain, liver, and adrenal glands; correct?
A That's correct.
Q And also small cell lung cancer commonly metastasizes to the brain; correct?
A That's correct.
Q That's why we have a patient like Mr. Kenyon who comes in with small cell lung cancer, you have to do a test to determine whether or not it spread; correct?
A Yes.
Q And Mr. Kenyon had all of those tests here; correct?
A Yes.
Q And there's no evidence of any metastasis or any spread to Mr. Kenyon's kidneys or adrenal glands; correct?
A Correct.
Q And there's no evidence of any

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metastasis or spread to Mr. Kenyon's liver; correct?
A That's correct.
Q And the same question: No evidence of any metastasis or spread to his bones; correct?
A Yes.
Q And there's no evidence of any metastasis or spread to his brain; correct?
A That's correct.
Q And Mr. Acosta asked you some question about his lymph nodes in his chest and mediastinum. There was no pathology from that area, from those mediastinum lymph nodes; correct?
A That's correct.
Q Okay. What that means is there was no tissue, no biopsy that was taken from those mediastinum lymph nodes from Mr. Kenyon; correct?
A That's correct.
Q And unless you have that pathology, that tests positive for cancer, you don't know for sure one way or the other as to whether that is or is not cancer in the lymph nodes?
A That's correct.
Q That's something that the pathologist, the one who looks under the -- you know, puts the slide under the microscope, that's something the

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pathologist would have to have looked at; correct?
A Correct.
Q And that was not done here; correct?
A That's correct.
Q Now I understand that small cell lung cancer can be classified as either limited or extensive; correct?
A Yes.
Q And Mr. Kenyon was diagnosed as limited; correct?
A Yes.
Q And you would agree that there was certainly cases of small cell limited to the chest that can be cured with radiation and chemotherapy; correct?
A That's true.
Q And I believe, if I heard you correctly, when Mr. Acosta was asking you questions, you said that the response to chemotherapy is excellent. I believe that's the word you used; is that correct?
A Yes. (nodding head).
Q I want to ask you now about some of these x-ray tests that are in your records. All right. Now, he had -- Mr. Kenyon had an chest, x-ray

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in May of 2000 -- I'm sorry, May of 2001, this year. And the radiologist who reviewed that film said there was no evidence of cancer. Do you recall that?

A No.

Q I'll show you that record. Can you read that?

A Yes.

Q Just take a moment to read it, and I'm going to ask you if you agree there is no indication on that radiology report of any evidence of cancer.

A I agree.

Q All right. And then in July of this year, July of 2000, Mr. Kenyon had a CT scan; correct? Do you recall that? I'll pull it up on the screen for you.

My question is, that radiologist listed four possibilities and said one of them might be neoplastic process, which is cancer, one of the four; correct?

A Yes.

Q And the radiologist there -- it says "this finding requires further evaluation." So, the radiologist suggested some further work-up; correct?

A Yes.

Q And Mr. Kenyon had -- you can take that

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one down. Let's go to the next one.
Mr. Kenyon had another chest x-ray in August. And that does not indicate any presence of cancer; correct?
A That's correct.
Q And you mentioned when Mr. Acosta asked you questions about thoracentesis, and let me ask you if this is correct. Thoracentesis is to the lung the same thing amniocentesis is to women who are expecting sometimes have; correct?
A Yes.
Q And that's just when you put a small needle in and you take out some fluid and you test that fluid; correct?
A Correct.
Q And -- when that fluid is taken out, when it's reviewed and tested, the pathologist does that; correct?
A Yes.
Q Again that's the doctor that looks under the microscope?
A Yes.
Q So, this thoracentesis was a test that you recommended after the radiologist came back and said "you need further work-up"; correct?

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A Yes.
Q And the test results from that test indicated there was no cancer present; correct?
A Correct.
Q And specifically, the pathologist there -- I believe it's Dr. Nicosia -- at Moffitt.
A Yes.
Q Do you know him?
A Yes.
Q That pathologist said in his report that there was no evidence of malignancy in this specimen; correct?
A Correct.
Q And that -- that was August of 2000. Now, that's not the first time he and a thoracentesis or a test of that fluid; correct?
A Correct.
Q He had had a previous one in October last year, October 2000; correct? And that was also a negative test; correct?
A Correct.
Q Now, I understand that back in August of this year that you recommended or -- maybe wrote a prescription, I'm not sure which is the right way to ask -- you recommended that Mr. Kenyon start a

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exercise regimen; correct?
A Yes.
Q Can you pull that back. 37.
This is your medical record there. It says "I have a written a prescription for physical therapy for gait and training and strengthening exercises." Correct?
A Yes.
Q Mr. Acosta asked you questions. He asked you some questions about COPD, and you said that was the same thing as emphysema. Do you recall that?
A Yes.
Q Now, there's no pathology report, no report from the pathologist that indicates that he has emphysema correct?
A Correct.
Q And the pathology would be the Gold Standard, the best way to determine whether or not there's emphysema present; correct?
A Correct.
Q Because if you don't have the pathology, the next best thing you can do is what's called a Pulmonary Function Test; correct?
A Correct.

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Q They're called sometimes in the medical records PFT as, Pulmonary Function Tests; right?
A Right.
Q And there are no PFT reports either from Mr. Kenyon that show the presence of emphysema; correct?
A Correct.
Q You were asked some questions by Mr. Acosta about Mr. Kenyon's sleep apnea. Now, are you aware that he was treated with that sleep apnea over in Sarasota?
A Yes.
Q Did you know that?
A Yes.
Q Okay. And were you aware that his doctors over in Sarasota who treated him for the sleep apnea said that his sleep apnea was caused by his weight. Did you know that?
A No.
Q That's not surprising to hear that, though, is it?
A No, that's not.
Q That's -- typically that's what sleep apnea is caused by; correct?
A (Nods head.)

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Q Were you aware Mr. Kenyon was put on oxygen by his doctors over in Sarasota for his sleep apnea before he was ever diagnosed with lung cancer? Do you know that?
A Yes.
Q Dr. Williams, I only have a couple of more questions to ask you.
Do you know what R.J. Reynolds' position is as to whether or not cigarettes are associated with some lung cancer? Do you know it?
A No.
Q And you understand that cigarettes are a lawful, legal product for adults who choose to smoke; correct?
A Correct.
Q And do you agree that here in the United States adults should have the right to choose whether or not they smoke?
A Yes.
MS. PARKER: I have no further questions.
Thank you, Dr. Williams.
THE COURT: Redirect.
MR. ACOSTA: Yes, just a few.
REDIRECT EXAMINATION

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BY MR. ACOSTA:
Q Dr. Williams, do you remember -- let me ask you this. What is central lobular emphysema?
A That's a pattern on a CAT scan of destruction of lung tissue.
Q Do you remember seeing an x-ray report by Mr. Kenyon that indicated that he had central lobular emphysema on CT scan?
A Yes.
Q With respect to pulmonary function studies; is that something that pulmonologist does?
A Yes.
Q That's not something that you do in your area?
A No.
Q Now, you were asked some questions about the diagnosis of small cell and indicated that it was a pathologic diagnosis made by a pathologist; is that right?
A That's correct.
Q And did your record indicate that both the pathologist at Sarasota Memorial Hospital and the pathologist at Moffitt had diagnosed small cell lung cancer?
A Yes.

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Q And then when you decide on a treatment plan for the care and treatment of small cell lung cancer, is that because small cell lung cancer behaves different than other forms of cancer when it comes to the treatment?
A Yes.
Q In Mr. Kenyon's case, did his cancer behave as a small cell lung cancer?
A Yes.
Q Would that have been primary to his lung in his case?
A Yes.
Q Is the vena cave syndrome; is that something that's consistent with the small cell lung cancer?
A Yes.
Q And the -- the lymphadenopathy, the enlargement in the mediastinum that you described; is that something that goes along with small cell lung cancer?
A Yes.
Q Now, you were asked some questions about risk reduction, and you were shown Mr. Kenyon's smoking history. Indicating that he had stopped smoking in 1982 two to three packs a day for 40

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years. Is that a significant dose of cigarette smoke?

A Yes.

Q And when you consider the dose of cigarette smoke, do you also consider in determining whether it's a cause of a particular cancer, do you consider the organs that are affected?

A Yes.

Q And is the lung one of the organs that's affected by cigarette smoke?

A Yes.

Q Now, is it biologically plausible that smoke cigarette causes lung cancer?

MS. PARKER: Objection, Your Honor.

THE WITNESS: Yes.

THE COURT: I'll overrule.

BY MR. ACOSTA:

Q And, Doctor, you were asked about other risk factors for cigarette smoking such as asbestos exposure, was there any indications in your treatment or any of the records that you saw that Mr. Kenyon had any disease caused by asbestos?

A No.

Q Was there any indication in any of the records that you saw or in your care and treatment of

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him that he had any disease caused by air pollution?
A No.
Q Was there any had indication -- now, I believe the one record I showed you that you may still have in front of from you May 5, 2000, you took a history of his alcohol consumption at that time?
A Yes.
Q Did it indicate approximately three glasses of wine per week?
A Yes.
Q Do you have an opinion as to whether that had anything to do with his lung cancer?
A Yes.
Q And what's the opinion?
A Doesn't have anything to do with his lung cancer.
Q Thank you. Now, with respect to any of these risk factors that were discussed, can you compare them to the risk factor of cigarette smoking?
MS. PARKER: Objection, Your Honor. Speculative. The witness said he had not evaluated those other risk factors.
MR. ACOSTA: Based --
THE COURT: I'll overrule.
THE WITNESS: Do I answer or --

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MR. ACOSTA: Yes.
THE WITNESS: Those risk factors that are associated are minor risk factors.
BY MR. ACOSTA:
Q Does cigarette operate in conjunction with other risk factors?
A Yes.
Q In what way?
A They enhance underlying lung damage from other risk factors.
Q Now, it indicates -- she asked you a question about one in ten cigarette smokers get lung cancer. You remember that question?
A Yes.
Q Now, did you understand that to include all smokers, somebody that just smokes a little bit and somebody that smoked a lot?
A No.
Q What group were you thinking about?
A Thinking of all smokers.
Q Would it be higher in some -- in a heavier smoker -- let me ask you this: Does the risk go up the more you smoke?
A Yes.
Q Now, with respect to the questions that

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were asked and the potential risk factors and the fact that your history indicated that he quit smoking in 1982. Even despite risk reduction, is it still your opinion that smoking was a cause of his lung cancer?

A Yes.

Q And the fact that he's had at least two pleural effusions since the original diagnosis, is that significant with respect to his future?

A Yes.

Q In what way?

A There's a problem in the chest.

MR. ACOSTA: Thank you, Doctor.

THE COURT: Ladies and gentlemen, do you have -- if you have a question, go ahead and raise your hand now.

JUROR #6: (Raises hand.)

THE COURT: We have one, very good. Ms. Parker, Mr. Acosta.

(Thereupon, the following bench conference was had:)

THE COURT: Is there an issue?

MR. ACOSTA: (Shrugs.)

THE COURT: Okay.

(Thereupon, the bench conference was

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concluded.)

THE COURT: Dr. Williams, how long does it take to develop chronic lung disease?

THE WITNESS: It varies. There are some people who have a proficiency of certain factors of the blood, who the get lung disease at an early age because of that. The most common situation is that occurs about 15, 20 years after prolonged occupational exposure of some sort like cigarette smoking.

So, generally we're talking about several years, 15 years. To get what's called chronic lung disease. Chronic lung disease can be due to infections like partially treated tuberculosis, can be due to airway abnormalities where people have a chronic infections, pneumonias and that kind of thing in children. In that case, chronic lung disease is -- develops more quickly.

THE COURT: Okay. And, Dr. Williams, how difficult is it to detect it during physicals?

THE WITNESS: Detect lung cancer during physicals?

THE COURT: Yes.

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THE WITNESS: It may be very difficult. Some of my patients are a symptomatic. In doing a routine physical examination, there may not be any clues from chest x-rays that there's cancer inside the chest.

JUROR #5: (Hands question to the bailiff.)

(Thereupon, the following bench conference was had:)

MS. PARKER: Is there a what?

MR. ACOSTA: Particular test.

THE COURT: Is there a positive test --

MR. ACOSTA: Yeah, okay.

MS. PARKER: (Shakes head.)

THE COURT: Kenny (pointing).

JUROR #6: (Hands question to the bailiff.)

(Thereupon, the following bench conference was had:)

THE COURT: All right, I'll re-ask the last question.

MS. PARKER: (Nods head.)

THE COURT: Okay. Is there an issue on that?

MR. ACOSTA: (Shakes head.) No, sir.

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MS. PARKER: No, sir. Thank you.
(Thereupon, the bench conference was concluded.)
THE COURT: Is it difficult to -- is it difficult to detect emphysema during a physical examination?
THE WITNESS: It is not very difficult if a person has typical symptoms and signs of emphysema which would be changing of the configurations of the chest, presenting with decreased breath sounds and having a history of chronic bronchitis and shortness of breathe. So, it's not very difficult to detect. Emphysema in and of it self is a pathologic term which means lung destruction so that under the microscope you see destruction of the air sacs.
THE COURT: Okay. Is there a reason to believe that if you smoke for less than 15 to 20 years, your chances of getting this cancer are greater and why?
THE WITNESS: No. There's not a reason to believe that. The less you smoke the better.
THE COURT: Is there a positive test to

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determine the cause of cancer regarding air pollution, asbestos, smoke?

THE WITNESS: No. There's no test that can be done to detect that.

THE COURT: Okay. Very good. Any follow-up questions, Mr. Acosta?

MR. ACOSTA: I just have one follow-up.

FURTHER REDIRECT EXAMINATION

BY MR. ACOSTA:

Q Doctor, with asbestosis, for example, there's a definite set of clinical criteria that are followed to determine whether or not a person would have asbestosis?

A Yes.

Q So, you are able to distinguish one disease from another clinically in terms of the presentation and the criteria that's set forth?

A Yes.

Q And so, asbestosis could be distinguished from lung cancer or some other disease?

A Yes.

MR. ACOSTA: Thank you.

THE COURT: Ms. Parker, anything?

MS. PARKER: I just have one question.

FURTHER RECROSS-EXAMINATION

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BY MS. PARKER:
Q Dr. Williams, all these risk factors we talked about, not just asbestos, but genetic issue, et cetera, you have not undertaken any type of study or investigation or evaluation of those issues with respect to Mr. Kenyon; correct?
A That's correct.
MS. PARKER: All right, thank you.
Thank you, Your Honor.
THE COURT: Thank you Doctor, you're free to step down, free to leave. Thank you very much sir.
Mr. Acosta, call your next witness.
MR. ACOSTA: Plaintiff would call Floyd Kenyon.
THE COURT: Very good.
MS. PARKER: Your Honor, may we approach?
THE COURT: You may. Mr. Acosta, come on up.
(Thereupon, the following bench conference was had:)
MS. PARKER: When this issue came up on the pretrial, on summary judgment that allowed --

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THE COURT: Just come on over here. After he gets -- yeah.

(Pause.)

THE COURT: Well, here's what -- here's what I'll do: I think it's appropriate, because we received this testimony and will give an instruction as to what the claim is. State the claim and we'll state what the claims are not. Okay?

So, I don't -- with regard to the proposed -- we'll do that over lunch, because we'll just move on. We're not going to get through Mr. Kenyon in 20 minutes. But at lunch, give -- get an instruction so I can tell them you're receiving this testimony, these are the claims, so you understand, these are the claims of the plaintiffs. These are the -- these are what's not being claimed.

MS. PARKER: Thank you, Your Honor.

(Thereupon, the bench conference was concluded.)

THE COURT: You want to take that --

MS. PARKER: No.

THE CLERK: You do swear or affirm that the evidence you shall give in this cause will

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be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

Thereupon,

FLOYD KENYON,

was called as a witness and, after having been first duly sworn/affirmed to testify the truth, was examined and testified as follows:

THE COURT: Thank you. Mr. Acosta, you may proceed.

DIRECT EXAMINATION

BY MR. ACOSTA:

Q Mr. Kenyon, would you tell the jury your full name and where you live.

A Floyd J. Kenyon. I live in [DELETED]

.

Q And, Mr. Kenyon, how long have you lived there?

A We've lived there now for six or eight months. We recently built this home. We had sold our home in the next town over -- I'm not good with names. I don't know -- a year and a half, two years ago and bought a piece of property in the next town

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over and planned to build. My wife is good at -- at house plans and decorating and so forth, and she's a love.

So, in selling our home, in order to be able to build, we needed the money from that. So, what we did was we rented an apartment in Sarasota --

Q Mr. Kenyon, let me digress for one second and ask you this: Did you plan to build the home that you live in now before you got lung cancer?

A Yes. Yes.

Q All right. And when did you move to Florida?

A Moved to Florida in 1984.

Q And where did you move to Florida from?

A Uh, from a town called Massapequa on Long Island, the south shore of Long Island.

Q Now, is your wife here with you in the courtroom?

A Yes, my wife is with me (pointing).

Q And what's her name?

A Florence -- she's known through her entire family as Honey, and she's a honey.

Q And where did you meet?

A We met in the halls of the third floor of Massapequa High School back in the mid '40s.

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Q What were you doing there at the time? You later worked at Massapequa High School, didn't you?
A Oh, I'm sorry.
Q When you met here, were you a student or a teacher?
A I met her at Baldwin High School, which is two towns over from where later we lived. Baldwin High School. We both went there and graduated from Baldwin High School. Also in town on the south shore.
Q Mr. Kenyon, do you have trouble with thinking or your memory?
A Yes, I do. I get confused often.
Q When do you recall that beginning?
A Uh, after I took brain radiation at Moffitt Hospital.
Q If you get confused with a question, would you please let me know that you are confused, if you can think of it. Would you do that?
A I will do that.
Q Now, do you remember approximately what year it was that you met your wife? Were you in high school. What year student were you?
A I'm going to give you 1945-ish.

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Q And then when did you get married?
A 1950.
Q And have you been married continuously to Florence, Honey, since 1950?
A Lovingly continuously.
Q And do you have any kids?
A We have three grown children, yes, we do.
Q And what are their names?
A My oldest's name -- her name is Carol. She is a school teacher on Long Island, and my middle's name is -- her name is Stephanie, and she owns and operates a -- a -- a public -- I'm sorry, a public relations company.
My youngest is my son, Junior; and he owns and operates a real estate appraisal company here in Tampa. I don't know if I mentioned the middle one runs her business in Virginia.
Q And are your children married?
A Yes. My oldest daughter is married. That's the teacher. She -- she is married to a man who's also in education, and they have two sons. One just graduated from college, and the other just ended as a freshman in college. My middle child, girl, Stephanie, has a girl, who is, I believe, a junior in

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high school in -- in Virginia; and a son who is an eighth grader in -- I think they call it middle school there. It's called junior high or middle school, stop school, different schools.

Q Were you invited to go to the graduation of Carol's children from college?

A Yes, I was.

Q Did you go?

A No, I didn't attend, and -- and I wanted to go badly.

Q Can you --

A But they -- they wouldn't -- we had to travel on Southwest Air, and they don't allow oxygen on Southwest Air. Some airlines do. You pay extra. That would have been okay if it would have been just a little bit extra, but it was like hundreds and hundreds of dollars extra; and I don't have oxygen-filling facilities up at my daughter's home. And we couldn't go, and (pointing) that hurt.

Q Can you tell the jury what your age is?

A I am 73 years old.

Q And where did you grow up?

A I grew up on Long Island. I was born in a town called Flushing. Just for information sake, it's where -- it's where Shea Stadium is for

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the Mets and the New York World's Fair in 1939 and 1964. So, I got -- some dates are there. But I basically grew up in Baldwin on Long Island, which is a country kind of a town far from New York City, far from the smog.

Q Are there any factories there?

A Yes, there would be factories there.

Q What kind of factories would be there?

A I don't really know. I really don't know.

Q Were there any -- did you spend most of your adult life on Long Island?

A All of our adult life after we graduated from high school and we moved to -- and got married, we moved to Massapequa and spent our lives there until we came down here.

Q Is that area an area of factories?

A Oh, no. Oh, no. That's not -- that's 35 to 40 miles away. It's almost as far from here to where we're living now in Sarasota. I mean, it's far.

Q Can you tell the jury what your educational background is?

A Yes. I graduated from what is today called Adelphi University. It was then Adelphi

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College, and my -- my wife attended Adelphi University. I have a sister who graduated from Adelphi University. I then went on to -- I was -- I went in the Marine Corps when I graduated from Adelphi.

Q Did you get a degree from another school?

A I -- when I got back from the Marine Corps, I -- I went and took my master's degree at Hofstra University, which is in the same general area. Both of them are on Long Island very close to where we lived, and I got my master's from there.

Q When were you in the Marine Corps?

A I was in the Marine Corps from 1951, '52, and '53 during the Korean situation.

Q Did you serve with any particular celebrity?

A Yes, I did.

Q Who was that?

A I was public information in the Marine Corps, and I was assigned to follow for a short time -- to follow Ted Williams. Ted Williams is a baseball player who probably is one of the all-time greats of the world; and he was a marine pilot. And he got called -- he was from World War II; but when

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Korea broke out, he -- he was called back, being a reservist. Some more good time out of his playing career. The poor guy.

So, anyway, I had this -- amongst other things, I wrote articles about Ted Williams and the Marine Corps. The Marine Corps is very, very acutely aware of -- of publicity. So, that was one of the things, yes.

Q Now, after you got of the Marine Corps, what did you do? You went to Hofstra and got a master's?

A I went to Hofstra while I taught.

Q Okay. You were teaching when that occurred?

A When I -- after I got out of the Marine Corps, yes.

Q And where did you teach?

A At Massapequa High School.

Q And what class did you teach?

A I was a history teacher. And today, I think they call it -- I don't know what they call it here, but I was a history teacher. Social studies, I think they call it. And I guess that's all. We had a history department.

Q Can you describe Massapequa High School

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for us? How big a place is this?
A Well, there's about 2,000 students in Massapequa High School. Later, it got -- it got a lot of overflow, so they built this second high school in town. Today that high school is back to being a junior high.
Q Now, how long did you teach history or social studies there at Massapequa High School?
A I think it was late -- no, it was the middle '60s, at which time I became a vice principal; and being a vice principal in a high school, regardless of what town it is, it's not easy. It's --
Q Did you have another job at the time?
A Yes, I did. I sold furniture after school and at night.
Q When did that begin?
A When did it begin? Almost -- almost immediately when I started teaching. The reason I did that might be hard for you guys and gals to believe; but when I started teaching, my initial salary for a year --
MS. PARKER: Objection, Your Honor.
THE COURT: Sustained. Go ahead and --
BY MR. ACOSTA:

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Q Mr. Kenyon, the response to the question, sir?
A Oh, I can't say that?
THE COURT: Right.
BY MR. ACOSTA:
Q Mr. Kenyon, you had a second job.
So, you taught. What happened to the selling of furniture job? Did that change at some point in time to --
A Yes. After a while, after maybe ten years, I opened my own store and had people working for me during the day while I was --
Q All right. And during that -- when did you open your own store? Do you have some time reference for that?
A Can you give me a minute? And I'll see if I can do some connecting.
Around 1964. Around that.
Q And is that about the time you became vice principal?
A I became vice principal in the latter years of -- of the '60s.
Q And then how long were you vice principal at Massapequa High School?
A I think it was about six years.

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Q And then what happened?
A Then I was appointed -- an opening came in an elementary school for a principalship. I don't have to tell you who raised their hands first; and my -- I had -- I was certified in your state as an administrator of both secondary and elementary schools. So, I was able to take over an elementary school.
Q Now, going back to Massapequa High School, where did your children go to school?
A All three of my children proudly went to Massapequa High School.
Q And were you a teacher or vice principal there when they were there?
A I was a vice principal when my oldest daughter was there.
Q And were you there for either of your other two children?
A I was not across them. My middle child went into the junior high before she got to me from the elementary school where I was going into. My -- my youngest was in the elementary school when I went there.
Q Now, did you retire from the elementary school?

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A I did that.
Q And when did you retire?
A 1984.
Q Then after retirement, what did you do?
A My wife and I opened a kitchen store, pots and pans and so forth, in Sarasota.
Q And when did you move to Sarasota?
A In 1984.
Q And how long have you run the kitchen store?
A Six or seven years. I'm not sure.
Q And then were you employed after that?
A Yes.
Q What did you do?
A My son's business up here in Tampa was doing so well, he couldn't get -- excuse me. He couldn't get help. And so, he said, "Dad, can you come up and help?" and from Sarasota to here.
I said, "You're my son. Yes, I can," and I did, and I started working in the office doing things for him, because I could not also appraise. You have to take courses and take state exams and so forth.
So, what I did was after a while, I -- I got my apprentice license in which I was able to do

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an appraisal, but he had to sign off on it. And I had to do two years or 200 jobs or both. I'm not -- it's in that category. And then you were admitted to take the state-certified course and prepare you for the state-certified exam, which is given in Orlando. And I did that for a few years under my son and then opened my own business, if you will, in Sarasota; and I did fairly well with that until -- until they took me to the hospital.

Q What are you referring to taking you to the hospital for?

A Ultimately, I -- I -- they told me -- why did I go into the hospital, you asked me? I went into the hospital because I was getting short of breath, and I -- I wasn't sleeping well, and my wife told me I was flailing in bed and so forth.

And so, we went to the -- to the GP in town in Sarasota, and he said, "It sounds like you're not getting a good night's sleep, and it could be sleep apnea," and he said, "I want you in the hospital now."

By the time we got to the hospital, which isn't that far away -- and my wife drove -- I -- I can remember very little. I was really reeling, and they put me in the intensive care unit

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and did all kinds of tests.
Q What did you learn?
A They told me that I had sleep apnea, that I had small cell lung cancer, and that I had emphysema -- and that I have emphysema. And they started me out on oxygen because I wasn't breathing well.
Q And up until the time, Mr. Kenyon, that you started to get -- how long before you went in the hospital did you notice having some shortness of breath and some trouble sleeping? How long was that before you went in the hospital?
A It had to be less than a year, but I'm not sure. I really am not sure.
Q One last question: How was your health in general up until that time?
A My health in general up until that time was top-notch. I mean, I had -- I had to go to the dentist or whatever, but --
MR. ACOSTA: All right.
THE COURT: Ladies and gentlemen, at this point we'll go ahead and take our lunch break, and I'll see you back here at 1:30.
THE WITNESS: At 1:30?
THE COURT: Well, you need to wait for

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a second for the jurors, first off.
(Thereupon, the jury exited the courtroom.)
THE COURT: Mr. Kenyon, you are in the middle of your testimony. So, you cannot discuss your testimony with anyone.
We will take our lunch break and resume at 1:30.
THE WITNESS: Can I go to my wife?
THE COURT: You just can't talk about your testimony with anyone.
THE WITNESS: But she's heard it.
THE COURT: You probably have other things you want to talk about with her.
THE WITNESS: Okay.
THE COURT: Y'all work on that instruction over the lunch break.
Anything further before we break for lunch?
MS. PARKER: What time do we come back?
THE COURT: 1:30. We start up at 1:30.
Very good. We'll be in recess until 1:30.
(Thereupon, a recess was had at 12:07 p.m.)

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COURT REPORTER'S CERTIFICATE

STATE OF FLORIDA)
CIRCUIT OF HILLSBOROUGH)

I, SHERRILL LYNN JACKSON, Court Reporter for the 13th Judicial Circuit of the State of Florida, in and for Hillsborough County,

DO HEREBY CERTIFY that I was authorized to and did report in shorthand the proceedings and evidence in the above-styled cause, as stated in the caption hereto, and that the foregoing pages numbered 952 to 1069, inclusive, constitute a true and correct transcription of my shorthand report of said proceedings and evidence.

Dated this 19th day of November, 2001.

_____
Sherrill Lynn Jackson, RPR

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